Department of Workforce Services

ELECTRONIC MAGNETIC MEDIA TRANSMITTAL INFORMATION

SUBMIT THIS SHEET WITH YOUR CARTRIDGE.

Please print. Fill in all areas except "DWS use only". Enter all employer names and account numbers submitted on the cartridge. Attach a list if additional space is required. *Quarterly reports must accompany cartridges unless filing via internet*

LIST VALID DWS ACCOUNT NUMBERS ONLY. NO FEIN NUMBERS OR "APPLIED FOR".

Company Name:_____ *DWS Account No.: _____

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Company Name:_____ *DWS Account No.: _____

Company Name:_____ *DWS Account No.: _____

Company Name:_____ *DWS Account No.: _____

A contact name and phone number must be supplied. Failure to comply may result in assessing a penalty in the event the cartridge cannot be processed.

Contact Name:_____ Title:_____

Phone # (_____) _____-_____ Extension.#_____

Fax# (_____)_____-_____

Email Address: _____

Please list the "RETURN TO" address for the cartridge. This information must be on the outside label as well.

Company Name: _____

Street Address: _____

City, State, and Zip Code: _____

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REQUIRED CARTRIDGE INFORMATION

Year _____ Quarter _____

Total Number of Records: _____ Total Number of Employers _____

ALL CARTRIDGES MUST USE A BLOCKING FACTOR OF "10" ONLY.

**************************************NO INTERNAL LABELS************************************

FOR DWS USE ONLY

Cartridge Number _____Post Mark Date _____Date Rcvd _____Qtr Rpt_____

Revised 02/22/07